

### Related Services Checklist for Transfer-In Students

(Note: Special Education Chairperson should review school records to determine if any related services are required at the current campus.)

**Student:** \_\_\_\_\_ **Student ID:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

	Related Service Type	Current Service Plan Available? (Circle Yes/No)		Evaluation Report Available? (Circle Yes/No)		If service plan is available, provide details for the current semester:			Name of Service Provider/Representative to Contact	Date Service Provider/ Representative Notified
						Duration ( time in minutes)	Frequency	Location		
1	Counseling Services	Yes	No	Yes	No					
2	In-home and Community Based Instruction	Yes	No	Yes	No					
3	Interpretive Services	Yes	No	Yes	No					
4	Itinerant Auditory Impaired Teacher Services	Yes	No	Yes	No					
5	Itinerant Visually Impaired Teacher Services	Yes	No	Yes	No					
6	Music Therapy	Yes	No	Yes	No					
7	Orientation and Mobility	Yes	No	Yes	No					
8	Parent Training	Yes	No	Yes	No					
9	Personal Care Services	Yes	No	Yes	No					
10	Psychological Services	Yes	No	Yes	No					
11	School Health Services	Yes	No	Yes	No					
12	Speech/Language	Yes	No	Yes	No					
13	Adapted Physical Education	Yes	No	If yes, provide Recommendations:						
14	Assistive Technology	Yes	No	If yes, provide Recommendations:						
15	Occupational Therapy	Yes	No	If yes, provide Recommendations:						
16	Physical Therapy	Yes	No	If yes, provide Recommendations:						
17	Transportation	Yes	No	If yes, provide Recommendations:						

**Comments:**

\_\_\_\_\_

**Form completed by:** \_\_\_\_\_ **Position:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Related Services Checklist for Transfer-Out Students

(Note: Special Education Chairperson should review school records to indicate the related services that need to be continued at the new campus.)

**Student:** \_\_\_\_\_ **Student ID:** \_\_\_\_\_ **School:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

	Related Service Type	Current Service Plan Available? (Circle Yes/No)		Evaluation Report Available? (Circle Yes/No)		If service plan is available, provide details for the current semester:			Remarks
						Duration ( time in minutes)	Frequency	Location	
1	Counseling Services	Yes	No	Yes	No				
2	In-home and Community Based Instruction	Yes	No	Yes	No				
3	Interpretive Services	Yes	No	Yes	No				
4	Itinerant Audiology Impaired Teacher Services	Yes	No	Yes	No				
5	Itinerant Visually Impaired Teacher Services	Yes	No	Yes	No				
6	Music Therapy	Yes	No	Yes	No				
7	Occupational Therapy	Yes	No	Yes	No				
8	Orientation and Mobility	Yes	No	Yes	No				
9	Parent Training	Yes	No	Yes	No				
10	Personal Care Services	Yes	No	Yes	No				
11	Physical Therapy	Yes	No	Yes	No				
12	Psychological Services	Yes	No	Yes	No				
13	School Health Services	Yes	No	Yes	No				
14	Speech/Language	Yes	No	Yes	No				
15	Adapted Physical Education	Yes	No	If yes, provide Recommendations:					
16	Assistive Technology	Yes	No	If yes, provide Recommendations:					
17	Transportation	Yes	No	If yes, provide Recommendations:					

**Comments:** \_\_\_\_\_

**Form completed by:** \_\_\_\_\_ **Position:** \_\_\_\_\_ **Date:** \_\_\_\_\_